

U.S. Department of State
MEDICAL HISTORY AND PHYSICAL EXAMINATION WORKSHEET
For use with DS-2053

OMB No. 1405-0113
EXPIRATION DATE: 05/31/2007
ESTIMATED BURDEN: 35 minutes
(See Page 2 - Back of Form)

Name (Last, First, MI)		Exam Date (mm-dd-yyyy)		
Birth Date (mm-dd-yyyy)	Passport Number	Alien (Case) Number		
1. Past Medical History (indicate conditions requiring medication or other treatment after resettlement and give details in Remarks) NOTE: The following history has been reported, has not been verified by a physician, and should not be deemed medically definitive.				
<table border="0" style="width: 100%;"><tr><td style="width: 50%; vertical-align: top;"><div style="display: flex; justify-content: space-between;"><div><div>No</div><div>Yes</div></div><div><div><input type="checkbox"/> <input type="checkbox"/></div> General Illness or injury requiring hospitalization (including psychiatric)</div><div><div><input type="checkbox"/> <input type="checkbox"/></div> Cardiology Angina pectoris Hypertension (high blood pressure) Cardiac arrhythmia Congenital heart disease</div><div><div><input type="checkbox"/> <input type="checkbox"/></div> Pulmonology History of tobacco use Current use <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma Chronic obstructive pulmonary disease (emphysema) History of tuberculosis (TB) disease Treated <input type="checkbox"/> Yes <input type="checkbox"/> No Current TB symptoms <input type="checkbox"/> Yes <input type="checkbox"/> No</div><div><div><input type="checkbox"/> <input type="checkbox"/></div> Neurology and Psychiatry History of stroke, with current impairment Seizure disorder Major impairment in learning, intelligence, self care, memory, or communication Major mental disorder (including major depression, bipolar disorder, schizophrenia, mental retardation) Use of drugs other than those required for medical reasons Addiction or abuse of specific* substance (drug) *amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, phencyclidines, sedative-hypnotics, and anxiolytics Other substance-related disorders (including alcohol addiction or abuse) Ever taken action to end your life</div></div></td><td style="width: 50%; 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2. Physical Examination (indicate findings and give details in Remarks) <div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/> No</div><div><input type="checkbox"/> Yes</div><div>Applicant appears to be providing unreliable or false information, specify _____</div></div>				
<div style="display: flex; justify-content: space-between;"><div>Height _____ cm</div><div>Weight _____ kg</div><div>Visual Acuity at 20 feet: Uncorrected L 20/ _____ R 20/ _____</div></div> <div style="display: flex; justify-content: space-between;"><div>BP _____ / _____ (mmHg)</div><div>Heart rate _____ /min</div><div>Respiratory rate _____ /min</div><div>Corrected L 20/ _____ R 20/ _____</div></div> <p style="text-align: center;">*N, normal; A, abnormal; ND, not done</p> <table border="0" style="width: 100%;"><tr><td style="width: 50%; vertical-align: top;"><div style="display: flex; justify-content: space-between;"><div><div>N*</div><div>A*</div><div>ND*</div></div><div><div><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></div> General appearance and nutritional status</div><div><div><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></div> Hearing and ears</div><div><div><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></div> Eyes</div><div><div><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></div> Nose, mouth, and throat (include dental)</div><div><div><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></div> Heart (S1, S2, murmur, rub)</div><div><div><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></div> Breast</div><div><div><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></div> Lungs</div><div><div><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></div> Abdomen (including liver, spleen)</div><div><div><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></div> Genitalia (including circumcision, infection(s))</div></div></td><td style="width: 50%; 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3. Additional Testing Needed Prior to Approving Medical Clearance

No Yes

☐ ☐ Physical examination or laboratory results contradict medical history

☐ ☐ Referral prior to departure If yes, provide results _____

☐ ☐ Referral prior to departure If yes, provide results _____

4. Follow-up Needed After Arrival

☐ No ☐ Yes, within 1 week ☐ Yes, within 1 month ☐ Yes, within 6 months

☐ For continuing medication, list type, dose, and frequency _____

☐ For continuing other treatment, specify _____

5. Remarks (describe any abnormal history, abnormal findings, and resulting interventions)

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICES

Public reporting burden for this collection of information is estimated to average 35 minutes per response, including time required for searching existing data sources, gathering the necessary data, providing the information required, and reviewing the final collection. Persons are not required to provide this information in the absence of a valid OMB approval number. Send comments on the accuracy of this estimate of the burden and recommendations for reducing it to: the U.S. Department of State (A/ISS/DIR) Washington, DC 20520.

AUTHORITIES The information is sought pursuant to Sections 212(a), 221(d), 101, and 412(b)(4) and (5) of the Immigration and Nationality Act.

PURPOSE The primary purpose for soliciting medical information is to determine whether an applicant is eligible to obtain a visa and alien registration. This form is designed to record the result of the medical examination required by INA 221(d), which determines whether an applicant has a medical condition that renders the applicant ineligible under INA Section 212(a).

ROUTINE USES The information solicited on this form may be made available to the U.S. Department of Homeland Security for disclosure to the Centers for Disease Control and Prevention and to the U.S. Public Health Service. The information provided also may be released to federal agencies for law enforcement, counter-terrorism and homeland security purposes; to Congress and courts within their sphere of jurisdiction; and to other federal agencies for certain personnel and records management matters. Although furnishing this information is voluntary, failure to provide this information may delay or prevent the processing of your case.